



STANDARDS OF POSTNATAL CARE FOR MOTHERS AND NEWBORNS: SURVEY REPORT

Qualitative and quantitative survey results



MARCH 28, 2017

PROVINCIAL COUNCIL FOR MATERNAL AND CHILD HEALTH

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Suggested citation: Provincial Council for Maternal and Child Health. (2017). Standards of Postnatal Care for Mothers and Newborns: Survey Report. Toronto, ON: Canada.

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About the Provincial Council for Maternal and Child Health

The Provincial Council for Maternal and Child Health has two distinct roles. First, it generates information to support the evolving needs of the maternal-child health care system in Ontario. Second, it is a resource to the maternal-child health care system in Ontario to support system improvement and to influence how services are delivered across all levels of care.

Vision

The best possible beginnings for lifelong health.

Mission

- Be the provincial forum in which clinical and administrative leaders in maternal and child health can identify patterns and issues of importance in health and health care delivery for system support and advice.
- Improve the delivery of maternal and child health care services by building provincial consensus regarding standards of care, leading practices, and priorities for system improvement.
- Provide leadership and support to Ontario's maternal and child health care providers, planners, and stewards in order to maximize the efficiency and effectiveness of health system performance.
- Mobilize information and expertise to optimize care and contribute to a high-performing system therefore improving the lives of individual mothers and children, providers, and stewards of the system.

Introduction

Approximately 140 000 babies are born in Ontario each year¹. In the context of early hospital discharges, rising health-care costs and constraints on resources, there is concern that the quality of postnatal care for the mother*/baby dyad during this transition period may be compromised. The Standards of Postnatal Care (SPNC) for Mothers and Newborns Expert Panel was established to articulate the provincial standards; identify a spectrum of postnatal models to facilitate the implementation of the standards for local adaptation; develop an evaluation framework to monitor the implementation of these standards; and identify or develop parent education tools to assist with the communication of the standards to families. One component of the project involved administering a provincial survey in order to identify innovative models or methods our colleagues used to coordinate postnatal care in the immediate postnatal period. Our goal was to use the survey results to identify models or methods for how the Standards should be implemented in Ontario and highlight implementation facilitators and barriers.

About the report

A subset of SPNC panel members informed the development of the survey. We included specific questions related to each standard but also general questions about facilitators, barriers, and unintended consequences (Please see Appendix A for the survey questions). The survey was distributed through our contacts and networks across the province via email, social media, and various maternal-newborn Listservs. A hardcopy version of the survey was also available upon request. The survey was open for a three-week period between October and November 2016.

This report summarizes the qualitative and quantitative results of the survey. The majority of the data was qualitative so two reviewers trained in qualitative methodology verified the topics/themes. Demographic information is presented first followed by a synthesis of the qualitative data as it related to each Standard. Finally, a summary of the overall themes across the Standards is presented.

**Please note that the term ‘mothers’ described in this report is meant to refer to all birth parents regardless of gender.*

¹ Statistics Canada. No date. *Table 102-4503*, Births and total fertility rate, by province and territory. CANSIM (database). Last updated October 26, 2016. <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth85a-eng.htm> (Accessed November 2016).

Demographic information

110 individuals responded to the survey. The majority of survey respondents identified themselves as administrators (n=36), nurses (n=24) or midwives (n=21). Survey respondents represented all regions of Ontario. The Local Health Integrated Network (LHIN) with the most survey respondents included the North East, South West, and Champlain LHINs. The Central West, North West, and South East LHINs had the lowest survey responses. The majority of survey respondents were employed at or affiliated with a level 2 hospital (n=41).

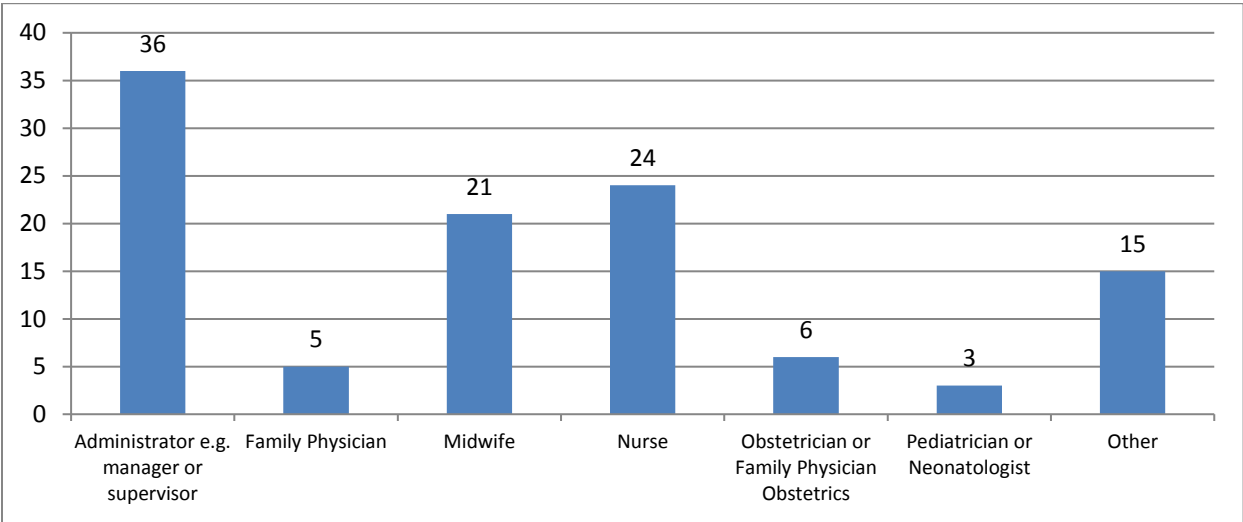


Figure 1: The survey respondent categories

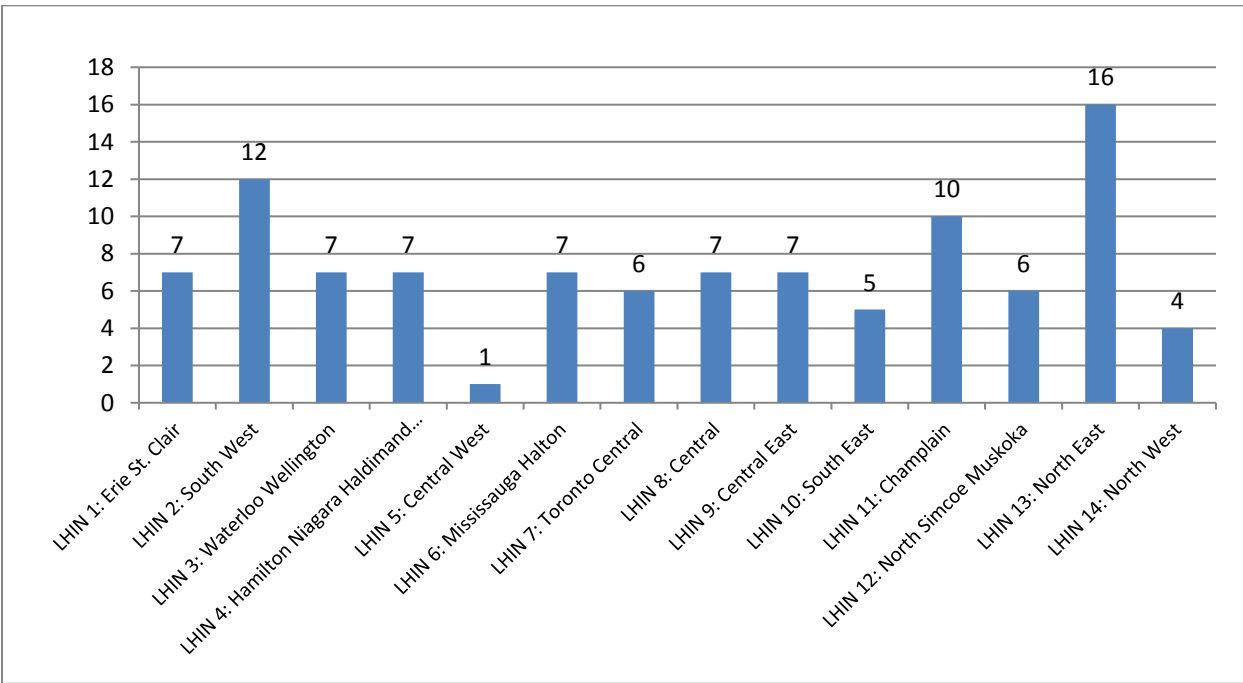


Figure 2: The LHINs that survey respondents belonged to

Standards of Postnatal Care for Mothers and Newborns: Survey Report

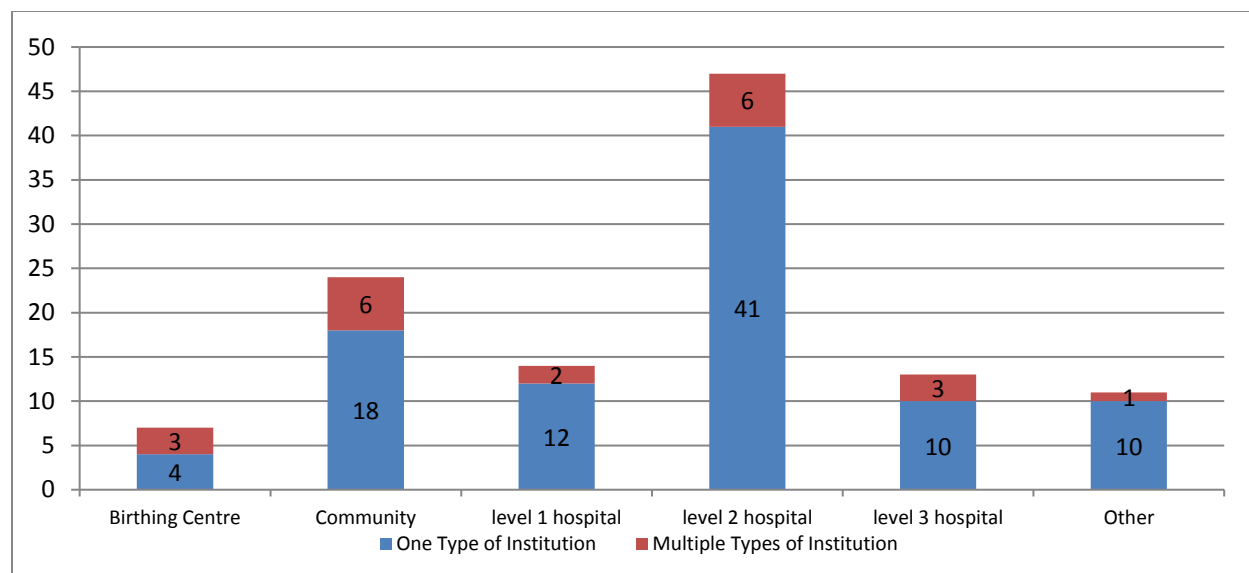


Figure 3: The institution(s) survey respondents identified with most

Breastfeeding

Home births

Midwives generally provided breastfeeding follow-up care and support but also made referrals to [breastfeeding] clinics, public health, or lactation consultants as necessary.

Facilitators	Areas for improvement
<ul style="list-style-type: none"> Strong partnerships and relationships. Start off small e.g. offer a breastfeeding service and then add to this program over time e.g. include jaundice services. 	<ul style="list-style-type: none"> Universal access to breastfeeding follow-up support and care.

Hospital births

Primary care providers (n=55) provided the majority of breastfeeding follow-up care and ongoing support once families were discharged. Clinics within the hospitals (n=40) and community clinics not associated with a hospital (n=37) also played an important follow-up and supportive role. Survey respondents stated that access to breastfeeding support, particularly on weekends and holidays, remained a challenge.

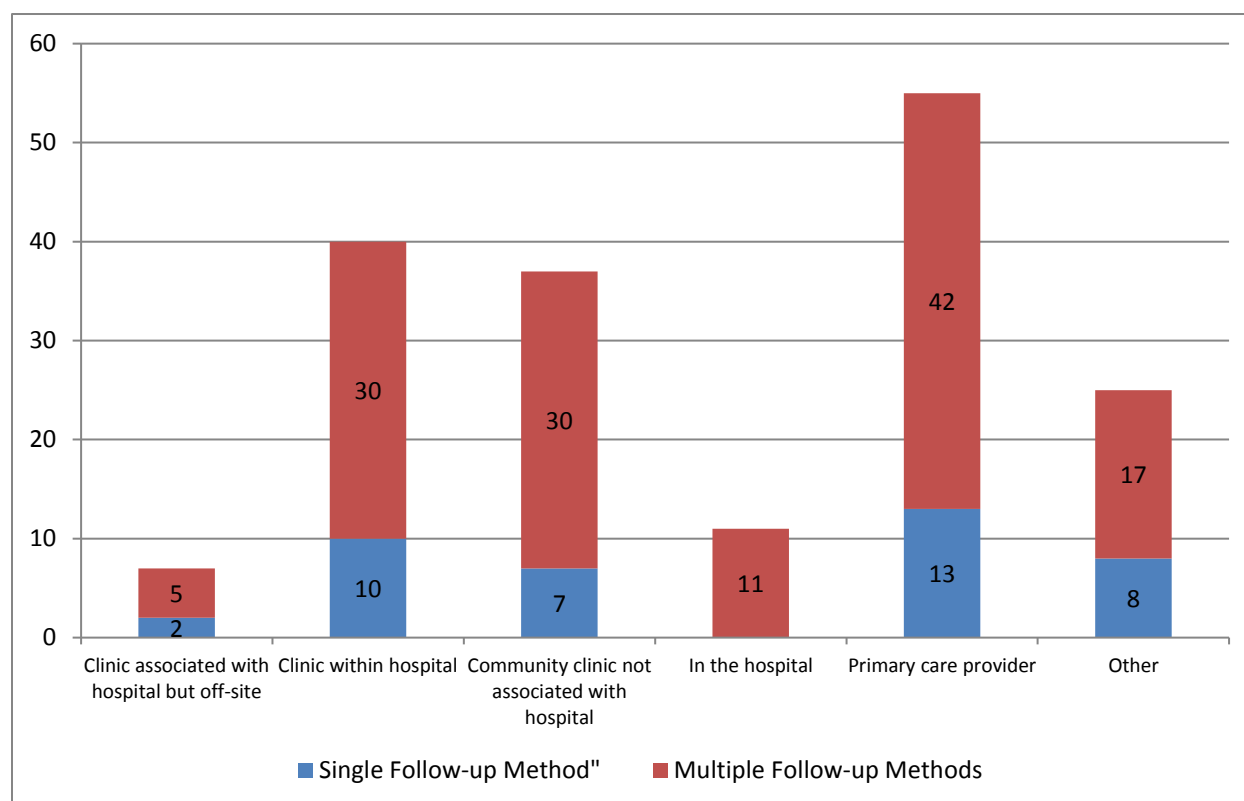


Figure 4: Breastfeeding follow-up and support for hospital births

Note: If survey respondents selected more than one place where families could receive follow-up care and support, all of the options were accounted for in red, under the 'multiple follow-up methods'.

I feel it has become so fragmented and new families are going all over the place in the early days to have the bits and pieces addressed. It seems to have become everyone else's problem. Funding was supposed to have moved from hospital to community but in the process has created many pockets of care. If a family is lucky enough to be in a large family practice group they have access to RN IBCLC who works to do some of the teaching and support. ... I often hear more and more mothers seek private support. So this tells me universal healthcare is not so universal after all. ... The reality is community partners need to stop working in isolation. All of us struggle with the reality of dollars and cents but this means partnerships working together for a common goal. ... With early discharge, this face to face support and assessment is even more critical to healthy outcomes. This needs to be built into every model of care.

-Hospital Nurse LHIN 3: Waterloo Wellington

Healthy Babies Healthy Children

The timing of when the Healthy Babies Healthy Children (HBHC) screen was administered during the birth to one-week postnatal period varied; however, it was typically administered within 48 hours of birth by a public health nurse, nurse, or midwife.

Survey respondents reported the following postnatal public health services being offered in their communities: a 48-hour phone call and offer of a follow-up visit for at risk women and a list of community resources for breastfeeding support and parenting classes.

In some institutions, public health staff administered the HBHC screen to mothers on the postnatal units in the hospitals and played an important role educating families about the community services that were available to them. Survey respondents viewed this partnership as particularly positive. This formal relationship led to more positive relationships between institutions and public health staff and resulted in consistent information sharing and higher rate of accurately completing the HBHC screens.

Several midwives noted that the HBHC screens were not immediately administered to mothers during this time since they were able to offer similar services. Thus, referrals to public health did not always occur right away.

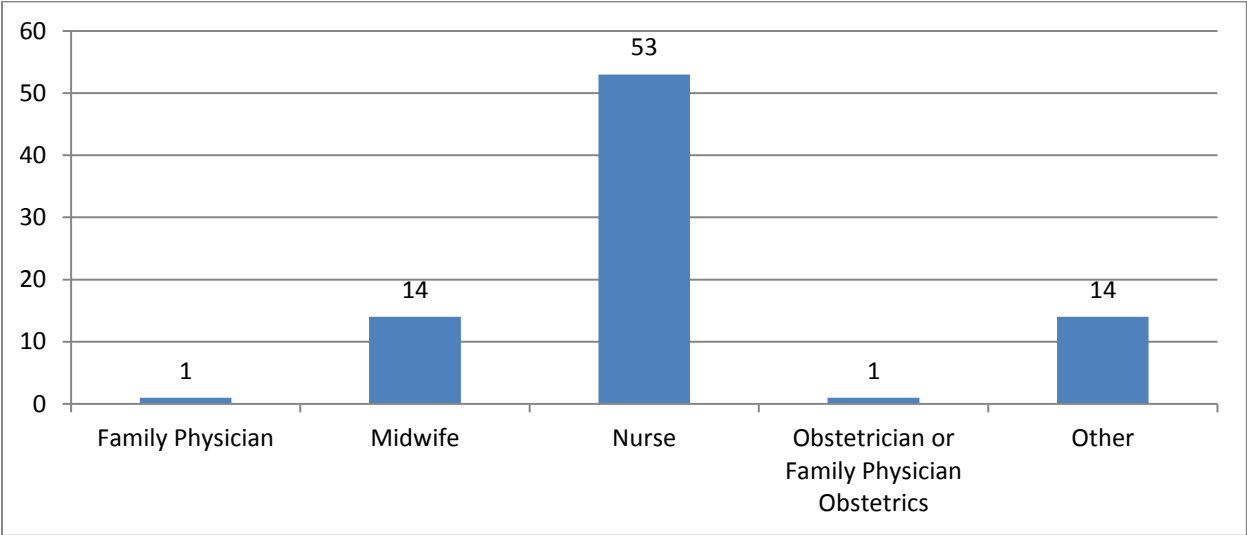


Figure 5: Individual responsible for administering the HBHC screen

Facilitators	Areas for improvement
<ul style="list-style-type: none">Having public health staff work alongside hospital staff to administer the screen and act as a resource regarding for community resources.	<ul style="list-style-type: none">Services for low-risk women and families*Extended operating hours e.g. on weekends and holidays.All families living in remote areas should receive a follow-up call and visit.

* The issue of low risk versus high risk clients came up in many responses. On the one hand, respondents valued HBHC's focus on high risk clients as it reduced duplication of services. On the other hand, some respondents saw the lack of services for low-risk patients as an opportunity for improvement, specifically as it related to early support for breastfeeding.

Jaundice/hyperbilirubinemia

Families typically received jaundice/hyperbilirubinemia follow-up care and support from primary care providers (n=39), clinics within hospitals (n=34) and in the hospital (n=34).

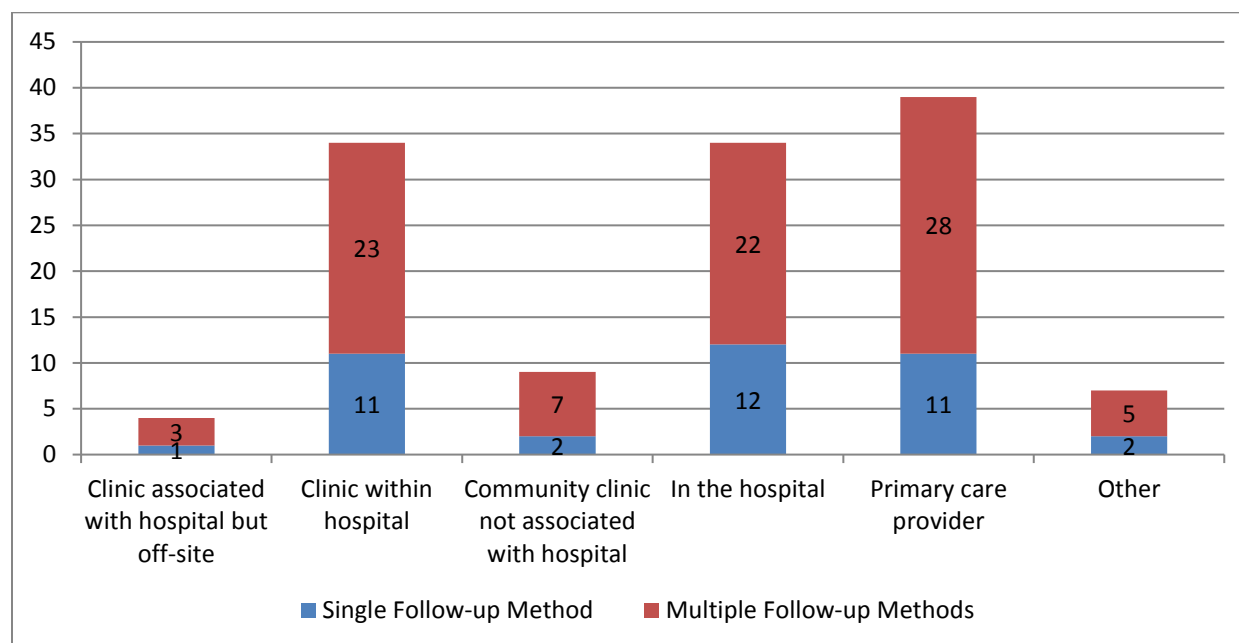


Figure 6: Places where families could receive jaundice follow-up and support

Note: If survey respondents selected more than one place where families could receive follow-up care and support, all of the options were accounted for in red, under the 'multiple follow-up methods'.

Facilitators	Areas for improvement
<ul style="list-style-type: none"> One physical location offering a range of maternal and newborn follow-up care and services. 	<ul style="list-style-type: none"> Improve access to testing locations on weekends and at nights. Standardize the implementation of the Hyperbilirubinemia Quality Based Procedure across the province. Midwives should have access to bilimeters to check for jaundice.

At one site we provide universal follow-up 2-3 days post discharge - excellent time to assess jaundice, weight loss and feeding problems. Clinic running for at least 15 years - very successful at finding vast majority of cases of hyperbilirubinemia requiring treatment. Savings on reduced newborn length of stay helped facilitate this clinic. Funding under ongoing scrutiny and have worked hard to keep this clinic running. Primary care in our area not easily accessed. Available by appointment 7 days per week all year - all newborns leave hospital with an appointment. Has decreased readmission rates by catching jaundice and feeding problems early.

-Pediatrician/Neonatologist from LHIN 9: Central East

Our capacity to provide competent newborn care post discharge in the community seems to be rapidly fading and our hospital care group believes that our babies would be best served by a universal community follow up clinic. The clinic would be multidisciplinary and would provide support for the newborn care for perhaps the first 10 days of life. Such a clinic would support breastfeeding, provide any needed lab follow up, provide identification of maternal and newborn complications and perhaps forge an opportunity to develop networks of peer support.

-Family Physician LHIN 4: Hamilton Niagara Haldimand Brant

Infant hearing screening

When survey respondents were asked what process took place to ensure the timely arrangement of infant hearing screenings in cases where screenings were not done in the hospital, the majority of survey respondents stated taking an active approach to arranging follow-up care for families. These respondents reported sending referrals directly to the providers or clinics in the community so families did not have to book their own appointments. Other survey respondents described a passive approach to arranging follow-up appointments for families. For example, they provided families with the information to book these follow-up appointments themselves.

The majority of families were referred to a community clinic not associated with the hospital (n=43) when they received a 'refer' screening result.

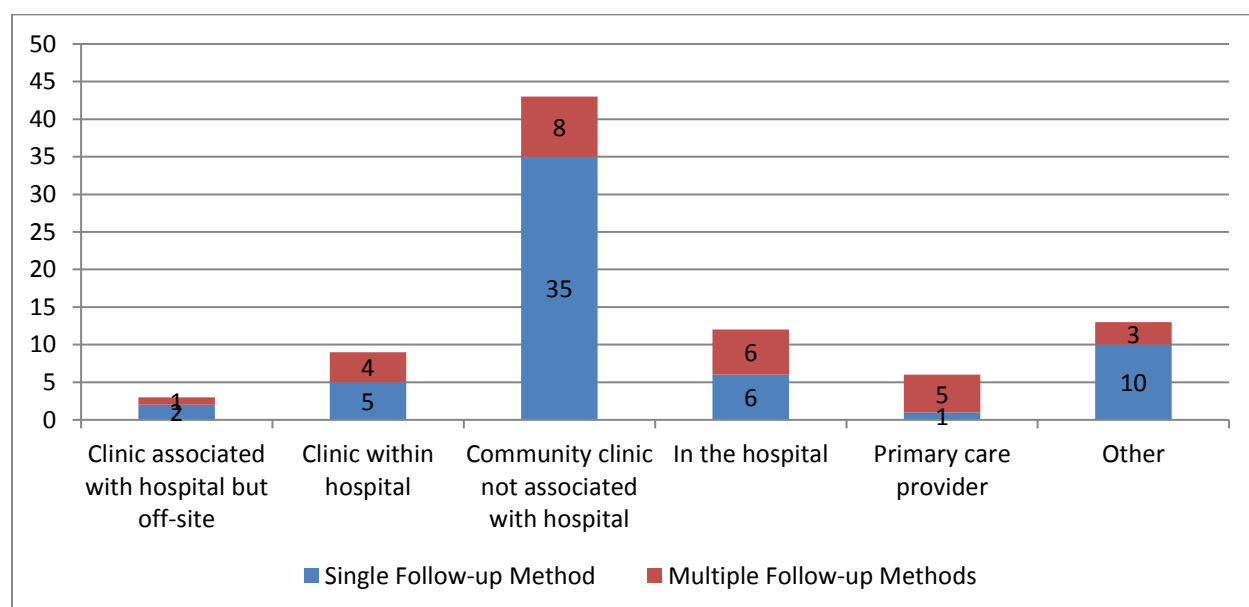


Figure 7: Places families are referred to when they receive a 'refer' screening result

Note: If survey respondents selected more than one place where families could receive follow-up care and support, all of the options were accounted for in red, under the 'multiple follow-up methods'.

Facilitators	Areas for improvement
<ul style="list-style-type: none"> Having dedicated infant hearing screeners e.g. public health, nurse, or hearing coordinator. 	<ul style="list-style-type: none"> Access to testing centres for families living in remote areas. Having an appropriate number of trained screeners available at all times. System to ensure that missed screens can be tracked. Opportunity for midwives to provide this service to clients.

Some barriers are if a patient is missed or failed and they live in a remote Northern community. This now becomes a very expensive test as they need to be flown back to a community that can deliver the test.

-Administrator LHIN 14: North West

From the midwifery perspective, the inability for midwives to perform this assessment/test meant that families have to leave their home for testing which may lead to fewer newborns being screened.

As midwives have never been given additional funding for hearing screening we [are] not able to provide this non-funded service. The current model is not working well as it only works weekdays during the day and no hearing testing is offered on the birthing unit, so all newborns must return for screening. I think it may lead to [fewer] newborns being tested.

-Midwife from LHIN 1: Erie St. Clair

Maternal mental health

Nurses were primarily responsible for administering a screen for maternal mental health in the immediate postnatal period (n=23). Physicians did not play a significant role in administering a maternal mental health screen to mothers in the immediate postnatal period (n=8).

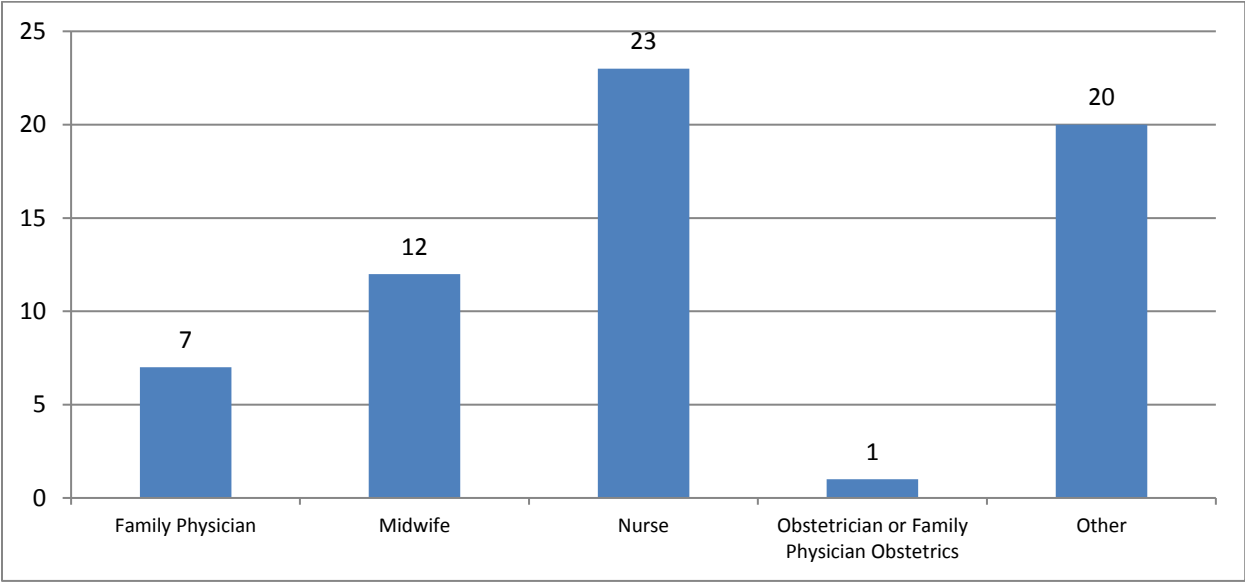


Figure 8: Individuals responsible for administering the screen

The timing of screening varied. It occurred before discharge, around the 48-hour mark, six weeks postpartum, or on a “as per needed” basis. Some survey respondents reported giving mothers a maternal mental health self-assessment tool to take home.

Facilitators	Areas for improvement
<ul style="list-style-type: none">Strong partnerships between community and mental health providers.Interprofessional team of mental health care providers to support families.	<ul style="list-style-type: none">Maternal mental health screening should be routine and a system should be set up to ensure that at risk mothers are flagged appropriately.Physical and operational access to psychiatrist or mental health services particularly in remote areas.

Newborn bloodspot screening

The following questions were posed to survey respondents regarding newborn screening (NBS):

If families are discharged before 24 hours, how do institutions ensure bloodspot screening between 24-72 hours?

Institutions ensure that families are scheduled a follow-up appointment. There were several comments from survey respondents, particularly those from LHINs 3, 6, 7, and 12, that families were not discharged before 24 hours unless they were midwifery clients.

How are newborn screening (NBS) samples tracked to ensure no one is missed?

Documentation of completed screens is recorded and data checks are performed internally using BORN data or another system to ensure no screenings are missed. Also, staff ensure that all newborns received the screening or had a follow-up plan in place prior to discharge as part of the usual discharge process.

If a repeat sample is needed, how is this process facilitated?

Although the majority of survey respondents stated they were unsure of how this was done, some survey respondents stated that Newborn Screening Ontario (NSO) notified their institution if a repeat sample was needed. Once the need for a repeat screening was flagged, midwives or hospital staff would follow-up with families to ensure that a plan was in place to get the repeat sample done.

Facilitators	Areas for improvement
<ul style="list-style-type: none">• Most respondents stated that the current process is working well.• Clear processes, procedures, and education established by NSO.	<ul style="list-style-type: none">• More training needed to ensure quality samples to avoid repeat sampling.• Enhance the accessibility of lab hours

Newborn exam

63% of routine newborn follow-up care was provided by primary care providers (n=44).

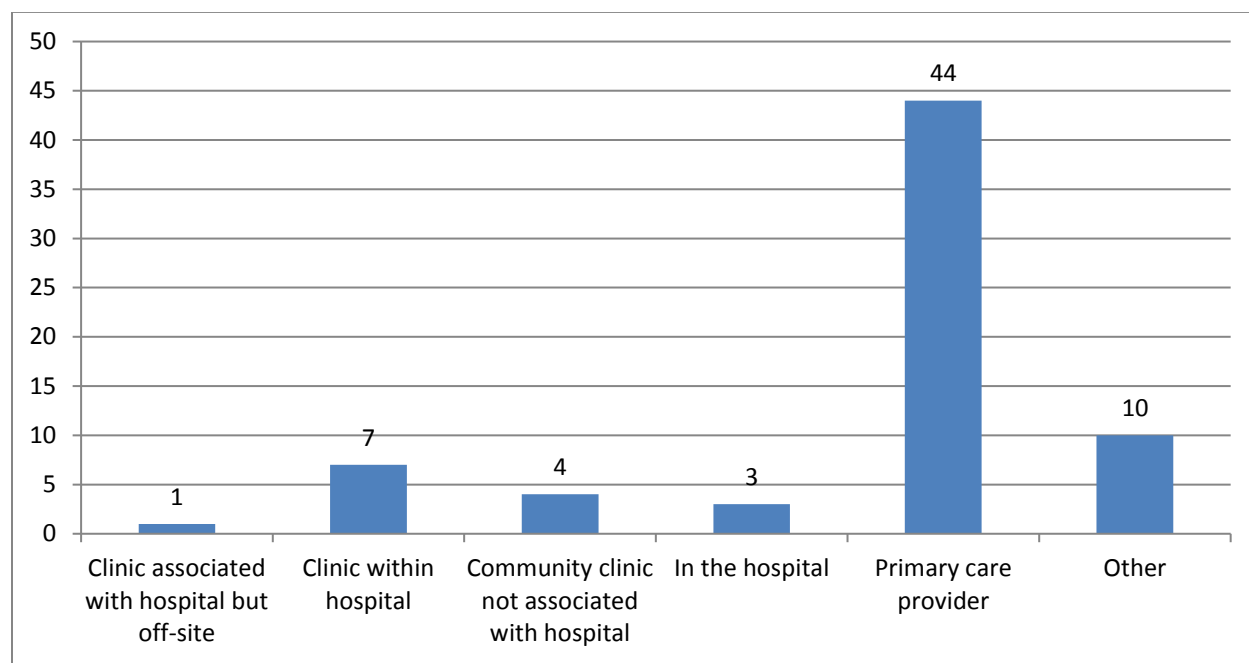


Figure 9: Place where routine follow-up care is provided for newborns

How is follow-up care arranged for babies where concerns are identified?

Referrals to appropriate staff or paediatric consultations were done while families were still in the hospital. Otherwise, depending on the severity of the condition, families were either encouraged to follow-up with the baby's health care provider in the community or referred to a newborn follow-up clinic.

Facilitators	Areas for improvement
<ul style="list-style-type: none"> Ensuring a system is in place to provide newborn postnatal care services to families who have yet to find a paediatrician or primary care provider. Clearly articulated processes, roles, and responsibilities. 	<ul style="list-style-type: none"> Timely and geographical access to paediatricians or primary care providers in every community. Emphasize the need for families to bring the discharge papers to the baby's primary care provider.

Overall themes

Analysis of the survey responses produced four key themes that are described in the following section.

Strong partnerships to support a continuum of care

Many of the models relied on strong partnerships and communication to support patients' transitions from hospital or midwifery care to community services. Good communication and interprofessional relationships between midwives, paediatricians, hospitals and community providers ensured that the right information was shared about patients at the right time to provide the best possible care. For example, comprehensive discharge summaries were used in many examples as a tool to communicate pertinent information to community providers. Further, having Public Health Units integrated in hospitals helped to establish early contact and facilitate transitions to community resources for families. However, there are still some gaps that prevent a completely seamless system of postnatal care. Providers identified the need for standard documentation (e.g. electronic medical records or Ontario postnatal record) that would facilitate communication between different practitioners and recognized the fragmentation of services, such as those related to maternal mental health, as an ongoing challenge. Where direct lines of communication and formal partnerships are not established and the onus is on parents and families to arrange follow-up appointments or communicate important health information, the chances are greater for people to fall through the cracks.

Resource sharing and optimization

In some of the described models, respondents identified opportunities to optimize system efficiencies by pooling resources with partners or relying on the expertise of other providers to carry out services. The Healthy Babies Healthy Children (HBHC) program by Toronto Public Health (TPH) provided some of the best examples related to this theme. One respondent said that having TPH staff perform the HBHC screen freed up hospital nursing staff to provide other types of care. As well, a number of respondents said that resources were better directed to babies and families who needed them the most as identified by HBHC. Beyond HBHC, the following quotation from a survey respondent provides another example of how providers optimally utilize existing resources to care for patients,

We currently offer access to a Mother and Baby Follow Up clinic 7 days a week from 0900-1600. It is co-located within our Maternal Newborn Area to allow for shared use of resources. We have partnered with Toronto Public Health and they provide 1.0 FTE of RN support for the clinic, while we fund 1.8 FTE of Nursing Support. All staff have or are working towards their Lactation Consultant certification.

- Administrator from LHIN 8: Central

Despite the gained efficiencies and saved resources that have come from partnerships, the need for more funding to maintain the continuum of postnatal care were repeatedly voiced in survey responses across all of the questions. Respondents said that while they were managing with stretched resources, there was an ongoing need for more to support staffing and space needs. The lack of community resources in some areas further spoke to the need for greater system resources.

Health equity

The survey responses highlighted many inconsistencies in postnatal care across the province. In some cases, the type of care a patient received was dependent on where they were located or who their care provider was. Responses from northern communities repeatedly spoke to issues with

patients accessing supports due to travel difficulties or the lack of availability of specialized services in their communities. These challenges were not flagged in other responses. In the case of certain conditions such as jaundice, respondents said that not all hospitals provide the same services for their patients. Further, some hospitals have established formal partnerships with specific community providers where others have not. For example, The Ottawa Hospital and the Monarch Centre share a formal partnership that has worked well for referrals, follow-up, information sharing and more to support patients and their families. Where these formal partnerships are not established in other regions, it is unclear whether patients receive the same supports in the postnatal period. The present variations in the type and quality of care that patients receive across the province confirm the need for standards of postnatal care.

The role of midwives

One of the greatest benefits of the midwifery model, as articulated by survey respondents, was the ability of midwives to provide their clients with regular home visits in the first week postpartum. The care offered in the home provided patients with a degree of comfort by keeping them in a familiar environment. This model of care was recognized as most effective in the areas of breastfeeding, maternal mental health and for newborn tests needed in the early postpartum period that would require a new mother to leave her home. Funding limitations mean that midwives are unable to complete some tests in the postpartum period (e.g. routine bilirubin testing). To compensate for this, a good referral system must be in place to help families access the care they need elsewhere.

Conclusion

It was clear from this survey that our maternal-newborn colleagues in Ontario are committed to the provision of high quality postnatal care for mothers and newborns during the birth to one-week postnatal period. This survey highlighted several methods or models that worked well for providers and institutions in different regions of Ontario. However, it was also evident that ensuring effective and timely coordination of postnatal care for mothers and babies in every region in Ontario continues to be a challenge. Thus, this remains an important issue and we should continue looking for ways to address these challenges to ensure high quality care for families in Ontario.

Appendix A: Coordination of quality postnatal care survey questions

COORDINATION OF POSTNATAL CARE FOR MOTHERS AND BABIES IN ONTARIO

What innovative methods or models have you or your institution adopted to ensure effective coordination of postnatal care for mothers and babies in the immediate postnatal period?

Project sponsor: Provincial Council for Maternal and Child Health (PCMCH)

Project lead: Diana An, PCMCH

Survey development team: Andrew Latchman, Christina Cantin, Ethel Ying, and Shannon Mantha (members of the Standards of Postnatal Care expert panel)

Survey support: Carla Santos and Vanessa Abban, PCMCH

Version date: October 11th 2016

Please submit the survey online by **9:00 a.m. Monday October 24th 2016**.

If you require a hardcopy of the survey or experience technical difficulties, please contact Carla Santos, Administrative Assistant, Carla.Santos@pcmch.on.ca or 416-813-7654 Ext. 228067. For all other questions, please contact Diana An, Senior Program Manager, at diana.an@pcmch.on.ca or 416-813-7654 Ext. 203667.

Thank you

Project Details

Background

Several challenges exist in the care of postnatal care for mothers and babies in Ontario: unclear postnatal care standards; insufficient time for comprehensive postnatal education, care, and follow-up; lack of clarity around the roles and responsibilities of hospital and community health care providers; and lack of standards to ensure timely and consistent information is provided to families. Establishing provincial standards of postnatal care will help ensure mothers and newborns are well prepared and supported from birth to the immediate postnatal period.

Objective

The overall project objectives are to:

- Articulate the standards of postnatal care for mothers and babies
- Identify models or methods for how these standards can be implemented across the province
- Develop an evaluation framework to monitor the impact on the health system, families, and providers
- Identify or develop relevant patient education materials

We believe it is important to engage stakeholders in the development stages of this project to ensure we do not reinvent the wheel but use this opportunity to learn from our colleagues in Ontario. We would like to invite you to share your experiences with us on how you and your institution effectively coordinate follow-up care for post-partum mothers and babies in Ontario. For example, some institutions have implemented a post-discharge care clinic where mothers and babies receive postnatal care such as breastfeeding support or follow-up newborn bloodspot screening. This is a great opportunity for you to showcase your leadership, celebrate your accomplishments, and share your strategies with your colleagues across Ontario.

Demographic information

1. Please indicate the category you identify with most (select one):

- Administrator e.g. manager or supervisor
- Family Physician
- Midwife
- Nurse
 - Community nurse
 - Hospital nurse
 - Public health nurse
 - Nurse practitioner
- Obstetrician or Family Physician Obstetrics
- Pediatrician or Neonatologist
- Other: Please specify _____

2. Which LHIN are you located in (LHIN 1-14)? _____ (<http://www.lhins.on.ca/> for map)

City:

Name of institution (if applicable):

Please indicate the type of institution you are with:

- Level 1 hospital
- Level 2 hospital
- Level 3 hospital
- Birthing Centre
- Community (please describe e.g. Family Health Team or Public Health)
- Other: Please specify _____

3. We would like the opportunity to contact you with further questions if needed. Your contact information will be used for the purposes of this project only and not shared with third party individuals without your permission. Please provide your contact information below.

- **Name:**
- **Email address:**
- **Phone number:**

Survey questions

We are interested in learning how our colleagues in Ontario are ensuring effective coordination of postnatal care for mothers and babies in the immediate postnatal period, e.g. the first week after birth and are seeking input on the following topics:

- Breastfeeding
- Healthy Babies Healthy Children (HBHC)
- Hepatitis B Immunoglobulin
- Jaundice/Hyperbilirubinemia
- Infant hearing
- Maternal mental health
- Newborn bloodspot screening
- Newborn exam
- Wound management

Breastfeeding

1. For hospital births, please indicate where the follow-up care and ongoing support is provided to families after discharge:

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider
- Other, please describe:

2. For home births, please describe how breastfeeding follow-up care and support is provided to families.

3. What is working well with this delivery model? Identify the facilitators that helped implement this model.

4. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Healthy Babies Healthy Children (HBHC)

1. Who is responsible for administering the screen?

- Family Physician
- Midwife
- Nurse
 - Community nurse
 - Hospital nurse
 - Public health nurse
 - Nurse practitioner
- Obstetrician or Family Physician Obstetrics

- Pediatrician or Neonatologist
- Other: Please specify _____

2. At what point in time does the screening occur during the post-partum period? E.g. 48 hours after birth

3. What follow-up does the public health unit provide to families in your region?

4. What is working well with this delivery model? Identify the facilitators that helped implement this model.

5. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Jaundice/Hyperbilirubinemia

1. Where is the follow-up and ongoing support provided?

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider
- Other
 - Please describe

2. What is working well with this delivery model? Identify the facilitators that helped implement this model.

3. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Infant hearing

1. Where is the follow-up in the event the screen is a “refer”?

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider
- Other
 - Please describe

2. If the screening was not done in the hospital, describe the process your institution takes to arrange the screening for infants.

3. What is working well with this delivery model? Identify the facilitators that helped implement this model.

4. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Maternal mental health

1. Do you currently have a screening process in place for maternal mental health in the postnatal period? If so, who is responsible for administering the screen?

- Family Physician
- Midwife
- Nurse
 - Community nurse
 - Hospital nurse
 - Public health nurse
 - Nurse practitioner
- Obstetrician or Family Physician Obstetrics
- Pediatrician or Neonatologist
- Other: Please specify _____

2. At what point in time does the screening occur during the postnatal period? (e.g.: 48 hours after birth)

3. Where is the follow-up and ongoing support provided?

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider
- Other
 - Please describe

4. What is working well with this delivery model? Identify the facilitators that helped implement this model.

5. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Newborn bloodspot screening

1. How do institutions ensure the newborn bloodspot screening is completed between 24 and 72hrs of age for families discharged before 24 hours of age?

2. How are newborn screening samples tracked to make sure no babies are missed?

3. If a repeat sample is needed, how is this process facilitated?

4. What is working well with this delivery model? Identify the facilitators that helped implement this model.

5. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Newborn exam

1. Where is routine follow-up care arranged for the newborns post discharge?

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider
- Other
 - Please describe

2. How is follow-up care arranged for babies in situations where specific concerns are identified in the initial exam?

3. What is working well with this delivery model? Identify the facilitators that helped implement this model.

4. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Maternal wound management

1. Where do mothers go to have their staples removed?

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider
- Other
 - Please describe

2. If the wound is suspected to be infected, where are mothers encouraged to seek treatment?

- Clinic associated with hospital but off-site
- Clinic within hospital
- Community clinic not associated with hospital
- In the hospital
- Primary care provider

- Other
 - Please describe

3. What is working well with this delivery model? Identify the facilitators that helped implement this model.

4. What are the areas for improvement? What barriers did you face when implementing this model? Were there any unintended consequences (positive or negative)? If so, please describe.

Would you like to provide any final comments about ensuring effective coordination of postnatal care for mothers and babies in the immediate postnatal period in Ontario?

Thank you for completing the survey. Please submit your survey to Carla Santos at Carla.Santos@pcmch.on.ca by Monday October 24th 2016 or mail to:

**Provincial Council for Maternal and Child Health
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